PART I

SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19D
REIMBURSEMENT FOR NURSING
FACILITIES
(OTHER THAN STATE-OPERATED FACILITIES)

Section A - General:

1. The purpose of this plan is to define the methodology for the establishment of reimbursement rates for nursing facilities participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan shall begin July 1, 1999.

2. The Department of Social Services requires each Medicaid participating nursing facility to complete and submit a uniform report, known as the "Statistical and Cost Summary for Nursing Facilities", to the Department within 150 days following the close of each facility's fiscal year. The reports shall be completed following generally accepted accounting procedures, the Medicare Provider Reimbursement Manual (HCFA Publication 15), and/or instructions from the Department. The accrual method of accounting is required.

3. The cost reporting period to be used for the establishment of the Medicaid reimbursement rates to be effective July 1, 1999, will be based on the nursing facility year-end cost report(s) from April 30, 1997 through March 31, 1998, and are commonly referred to as the 1997 cost reports.

4. All providers shall be required to keep all financial and statistical records for a minimum of six years following the submission of cost reports and these records must be made available to the Department of Social Services and/or Medicaid Fraud Unit (MFCU) and/or Department of Health and Human Services (HHS) upon request. In no instance shall the records required by this paragraph be knowingly destroyed when an audit exception is pending.

5. All cost reports submitted will be maintained in the Department's files for a minimum of six years or until any audit exceptions are cleared, whichever is longer.

6. Participation in the program as a provider of nursing facility services shall be limited to those facilities that accept as payment in full the reimbursement established under this plan for the services covered by the plan.

7. Nursing facilities shall be classified as shown below:

CLASSIFICATIONS

A. Level I - All non-waivered nursing facilities participating in the South Dakota Medicaid Program.

B. Level II - Waivered

A Level II Waivered Nursing Facility is a nursing facility that is operating under an approved waiver, granted by the South Dakota Department of Health, regarding professional nurse staffing requirements.

8. All nursing facilities must meet nursing facility requirements and OBRA requirements as required under certification and licensure standards.

9. Field audits of cost reports shall be conducted that shall meet or exceed the scope of Title XVIII specifications. All facility cost reports may be desk audited, with field audits conducted as necessary. Additionally, all facilities may be audited prior to any ownership change, the scope of the audit to be determined by the Department of Social Services.

10. All audit exceptions shall be accounted for on the HCFA 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

Section B - Cost Reporting Conditions;

1. Rent paid to a related organization shall be disallowed and actual cost of ownership shall be reported. For purposes of this plan, cost of ownership is defined as mortgage interest, plus depreciation on building(s), plus depreciation on equipment, plus repairs to building(s), plus repairs to equipment, plus insurance on building(s), plus insurance on equipment, plus property taxes.

2. The provider shall identify all related organizations to whom reported operating costs were paid. Identification of the amount of these costs, the services, facilities, supplies furnished by or interest paid to a related organization shall be attached to the annual cost report. Costs shall not be allowed to exceed the lesser of actual cost to the related organization or the open market cost.

3. Allowable costs are based upon criteria as defined in HCFA-15, Provider Reimbursement Manual, except as otherwise described below.

   Routine Services. Routine Services shall be defined as those services and items which are necessary in meeting the care, treatment and comfort of the residents. The following items and services will be considered to be routine for purposes of Medicaid cost reporting and included in the Medicaid per diem rate.

   a. All general nursing services, including administration of oxygen and medications; handfeeding; care of the incontinent; tray service; normal personal hygiene which includes bathing, skin care, hair care, nail care, shaving, and oral hygiene; etc.;

   b. Items used in the care and treatment of residents, such as alcohol, applicators, cotton balls, Band-Aids, linen savers, colostomy supplies, catheters, catheter supplies (eg, bag), irrigation equipment, needles, syringes, I.V. equipment, support hose, hydrogen peroxide, enemas, screening tests (such as: Clinitest, Testape, Ketostix, etc.), tongue depressors, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.) and over-the-counter medications;

c. Items which are utilized by individual residents but which are reusable and expected to be available, such as resident gowns, water pitchers, bedpans, ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;

d. Social Services and Activities including supplies for these services;

e. At least 3 meals/day planned from the Basic Four food groups in quantity and variety to provide the medically prescribed diets. This includes special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as prescription item by a physician - as these supplements have been classified by the FDA as a food rather than a drug;

f. Laundry Services;

g. Therapy Services when provided by facility staff or by a consultant under contract with the facility;

h. Transportation services necessary to meet the medical and activity needs of the residents exclusive of commercial ambulance and specialized wheelchair transportation services.

i. Oxygen, regulators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and,

j. Oxygen concentrators;

k. Respiratory Services and Supplies (Respirator/Ventilator Equipment will be subject to Section D, Provision Number 11).

Non-Routine Services. These services are considered ancillary for Medicaid payment. The costs of these services should be accounted per instructions for completing the Statistical and Cost Summary Report. The costs of these services must be billed by the physician, laboratory, pharmacy, agency, supplier, or therapist providing the service.

a. Prescription Drugs;

b. Physician services for direct resident care;

c. Laboratory and Radiology;

d. Mental Health Services;

e. Therapy services when provided by someone other than a facility employee; and,

f. Prosthetic devices and supplies for prosthetic devices provided for an individual resident.

g. Services provided by independent medical practitioner for the direct care of patients.

4. Reasonable costs shall be "appropriately documented allowable costs" that do not exceed the following limitations:

a. Direct care costs (as defined in the Medicaid Cost Report and Instructions) shall be Case Mix adjusted and limited as follows: Effective July 1, 1999, the median cost is to be based on all Level I non-waivered nursing facilities that have a case mix acuity level of 1.00 or more. The Department will then establish a minimum ceiling at 115% of the median, and a maximum ceiling at 125% of the median.

(1) Effective for State Fiscal Year 2000 the Medicaid Program will pay 95% of the costs between the 115% ceiling and the 125% ceiling.

(2) Effective for State Fiscal Year 2001 the Medicaid Program will pay 90% of the costs between the 115% ceiling and the 125% ceiling.

(3) Effective for State Fiscal Year 2002 and thereafter the Medicaid Program will pay 80% of the costs between the 115% ceiling and the 125% ceiling.

Any costs in excess of 125% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

b. Health & Subsistence costs (consist of the cost categories of Health & Subsistence, Plant/Operation and Other Operating as defined in the State Medicaid Cost Report) shall be limited as follows: Effective July 1, 1999, the median cost is to be based on all Level I non-waivered nursing facilities that have a case mix acuity level of 1.00 or more. The Department will establish a minimum ceiling at 105% of the median, and a maximum ceiling of 110% of the median.

(1) Effective for State Fiscal Year 2000 the Medicaid Program will pay 95% of the costs between the 105% ceiling and the 110% ceiling.

(2) Effective for State Fiscal Year 2001 the Medicaid Program will pay 90% of the costs between the 105% ceiling and the 110% ceiling.

(3) Effective for State Fiscal Year 2002 and thereafter the Medicaid Program will pay 80% of the costs between the 105% ceiling and the 110% ceiling.

Any costs in excess of 110% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

c. Administrative costs (as defined in the Medicaid Cost Report) shall be limited as follows: Effective July 1, 1999, the median cost is to be based on the administrative costs of all freestanding non-chain organization affiliated nursing facilities. The Department will establish a minimum ceiling at 105% of the median, and a maximum ceiling of 110% of the median.

(1) Effective for State Fiscal Year 2000 the Medicaid Program will pay 95% of the costs between the 105% ceiling and the 110% ceiling.

(2) Effective for State Fiscal Year 2001 the Medicaid Program will pay 90% of the costs between the 105% ceiling and the 110% ceiling.

(3) Effective for State Fiscal Year 2002 and thereafter the Medicaid Program will pay 80% of the costs between the 105% ceiling and the 110% ceiling.

Any costs in excess of the 110% limitation will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

d. Capital costs shall be limited to $9.94 per resident day for all nursing facilities participating in the State Medicaid Program. (See Section C, Provision Number(s) 3, 4, 5, & 6).

5. A return on net equity shall be an allowable cost for proprietary facilities. The allowable rate of return shall be the average mid-point of the prime interest rate and the rate of 180-day U.S. Treasury Bills, as reported on the last business day of June, September, December, and March. The rate of return shall not exceed 10% and will be calculated on the provider's fiscal year-end balance sheet of the cost report required in Section A, Provision Number 3.

6. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally-accepted accounting procedures will be used in determining the life of any addition(s) and improvements to primary structures. Effective July 1, 1999, the capital basis for depreciation of new construction, major renovation, and or any facilities acquired through purchase, must be subject to a salvage value computation of at least 15% (Section C, Provision Number 6).

7. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.

8. Depreciation on major moveable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item purchased after January 1, 1987. Deviations from the AHA Guidelines may be granted in those instances in which facilities can provide the Department with documented historical proof of useful life.

Section C - Limits and Ceilings:

1. Direct Care Case Mix Adjusted Cost - 115% to 125%

The method used to determine the Direct Care Case Mix Adjusted Cost will be: (1) Calculate the average Case Mix Score for each facility during the cost reporting period, (Section A, Provision Number 3); (2) Determine the per diem Case Mix Component Cost for each facility from the cost report (Section A, Provision Number 3); and (3) Divide each facility's per diem Case Mix Component cost by its Case Mix Score to arrive at the facility's Case Mix Adjusted Per Diem Cost. The Case Mix Adjusted Per Diem Cost will then be used to establish a minimum ceiling at 115% of the median and a maximum ceiling at 125% of the median. The Medicaid Program will only pay a stated percentage of all costs in excess of the 115% (Section B, Provision Number 4a). Any costs in excess of 125% will not be recognized. The ceiling limitations will apply to all nursing facilities participating in the State Medicaid Program.

2. Non-Direct Care Cost

The Non-Direct Care Cost components will consist of: (1) General Administrative; (2) Health and Subsistence; (3) Other Operating; (4) Plant/Operational; and Capital. The Non-Direct Care Costs will not be subject to Case Mix Adjustment.

Non-Direct Care Costs will be limited by establishing three separate cost categories and establishing ceiling limitations for each.

a. Health & Subsistence Costs - 105% to 110%
This category will consist of the cost categories of Health & Subsistence, Plant & Operation and Other Operating, as defined in the Medicaid Cost Report. The median cost is based on all Level I non-waivered nursing facilities that have a case mix acuity level of 1.00 or more. A minimum ceiling will be established at 105% of the median and a maximum ceiling will be established at 110% of the median. The Medicaid Program will only pay a stated percentage of costs in excess of the 105% limitation (Section B, Provision Number 4b). Any costs in excess of the 110% limitation will not be recognized.

b. Administrative Costs - 105% to 110%

The median cost of administrative costs will be based on the administrative cost category, as defined in the Medicaid Cost Report, and will be based on the administrative costs of all freestanding non-chain organization affiliated nursing facilities. A minimum ceiling will be established at 105% of the median and a maximum ceiling will be established at 110% of the median. The Medicaid Program will only pay a stated percentage of the costs in excess of the 105% limitation (Section B, Provision Number 4c). Any costs in excess of the 110% limitation will not be recognized.

c. Capital Cost - Dollar Limitation

The Capital Cost Components will consist of: (1) Building Insurance, (2) Building Depreciation, (3) Furniture and Equipment Depreciation, (4) Amortization of Organization and Pre-Operating Costs, (5) Mortgage Interest, (6) Rent on Facility and Grounds, (7) Equipment Rent and, (8) Return on Net Equity. The Capital Cost will be limited to $9.94 per resident day for all participating nursing facilities.

3. Leased Facility - maximum capital costs for a leased facility are limited to the following:

a. The maximum capital costs for facilities negotiating new leases and facilities renewing existing leases after June 30, 1999, is limited to the lower of actual costs or to the capital cost limitation per Section C, Provision Number 2.c. The capital cost components for computing the above limit shall consist of: (a) rent on facility/grounds and equipment; (b) building insurance; (c) building depreciation; (d) furniture and equipment depreciation; (e) amortization of organization and pre-operating costs; (f) capital related interest; and, (g) return on net equity. The capital cost items are allowable only if incurred and paid by the lessee. Capital costs will not be recognized in any other manner than as outlined in this section if incurred by the lessor (owner) and passed on to the lessee.

b. The maximum allowable for rental payment(s) for facilities negotiating a new lease and facilities renewing existing leases after June 30, 1999, are limited to the lower of actual lease costs or 70% of the weighted average per diem cost of the capital costs for owner-managed facilities.

c. The maximum allowable capital costs for facilities with a valid lease prior to June 30, 1999, shall be the capital cost as recognized (subject to limitations) by the Department on July 1, 1998.

d. No reimbursement shall be allowed for additional costs related to sub-leases.

4. For reimbursement purposes outlined under this plan, any lease agreement entered into by the operator and the landlord shall be binding on the operator or his successor(s) for the life of the lease, even though the landlord may sell the facility to a new owner. For reimbursement purposes outlined under this plan, the only exceptions for permitting the breaking of a lease prior to its natural termination date shall be:

a. the new owner becomes the operator; or,

b. the owner secures written permission from the Secretary of the Department of Social Services to break the lease.

5. The maximum allowable capital cost for an owner-managed facility shall be limited to $9.94 per resident day for all nursing facilities. Beginning July 1, 2000 and annually thereafter, the capital cost limitation will be inflated by one/half the annual percentage of cost change from the previous year to the current year, calculated by using the Means Building Index for South Dakota.

6. New construction notification - Effective July 1, 1999, all nursing facilities that are planning to undertake new construction of a nursing facility, and/or a major expansion, and/or renovation project are required to notify the Department of Social Services, in writing and prior to the start of construction, regarding the scope and estimated cost(s) of the project. For purposes of this notification requirement any improvement, repair or renovation project will be defined as any improvement or repair with an estimated cost of $125,000 or more.